Date: \_\_\_\_\_

Employer Name \_\_\_\_\_ Employee Name \_\_\_\_\_

G Additional Information - Separate Sheet		
If you answered "Yes" to <u>any</u> of the questions above, you must complete this section.		
Question Number:	Name of Individual:	
Condition/Diagnosis:		Date Diagnosed (MM/YYYY):
Treatment Received:		
	No	
Treatment ongoing?		
Medication Prescribed (if any):		
		Currently taking medication?   Yes   No
Question Number:	Name of Individual:	
Condition/Diagnosis:		Date Diagnosed (MM/YYYY):
Treatment Received:		
Surgery, additional tests or treatment recommended?		
Medication Prescribed (if a		Currently taking medication?   Yes  No
		Currently taking medication?   Fes   No
Question Number:	Name of Individual:	
Condition/Diagnosis:		Date Diagnosed (MM/YYYY):
Treatment Received:		
Treatment anging Q \( \sqrt{\text{V}}\)	a D No Lost Treatment Date.	
Treatment ongoing?		
		Currently taking medication?   Yes   No
Question Number:	Name of Individual:	
Condition/Diagnosis:		Date Diagnosed (MM/YYYY):
Treatment Received:		
Treatment ongoing?  No Last Treatment Date:		
Surgery, additional tests or treatment recommended?		
ivieuication Prescribed (IT a	IIy)	Currently taking medication? ☐ Yes ☐ No
		Currently taking modification: [] 165 [] 110

Signature: